Office of Health Care Assurance

**State Licensing Section**

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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|---|---|
| **Facility's Name: J & J** | **CHAPTER 100.1** |
| **Address:**<br>**94-276 Pupukoae Street, Waipahu, Hawaii** | **Inspection Date: May 8, 2019 Annual** |

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**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-9 Personnel, staffing and family requirements. (e)(3)<br>The substitute care giver who provides coverage for a period less than four hours shall:<br><br>Be currently certified in first aid;<br><br>**FINDINGS**<br>Substitute caregiver (SCG) #3, no first aid certification. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** | |

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| ☒ | §11-100.1-9 Personnel, staffing and family requirements. (e)(3)<br>The substitute care giver who provides coverage for a period less than four hours shall:<br><br>Be currently certified in first aid;<br><br>**FINDINGS**<br>Substitute caregiver (SCG) #3, no first aid certification**.** | **PART 2**<br><br>**FUTURE PLAN**<br><br>**USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** | |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
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| ☒ | §11-100.1-13 Nutrition. (l)<br>Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets.<br><br>**FINDINGS**<br>Resident #1, no evidence menu available for special diets. Posted regular menu had written notes for each resident with a special diet order in the footer. For Resident #1, diet order (4/1/19) reads "Heart Healthy 2 gm Na Pureed." Posted menu note in the footer for resident reads "Heart Healthy 2 gm Na Pureed Thick-it, Liquid Nectar consistency." | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** | |

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| ☒ | §11-100.1-15 Medications. (e)<br>All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.<br><br>**FINDINGS**<br>Resident #1, discrepancy between manually signed order and electronically signed orders on same date as follows:<br><br>1. Electronically signed order (2/13/19) reads, "Carvedilol 25 mg tab, 1 tab twice a day with meal (increased dose)." Manually signed order (2/13/19) reads, "Carvedilol 12.5 mg BID po.) However, the medication administration record (MAR) 2/13/19 reads, "Carvedilol 12.5 mg BID for HTN hold SBP <100 mmg or HR < 60" continued.<br><br>2. Electronically signed order (2/27/19) reads, "Resume Lasix 20 mg QD." Manually signed order (2/27/19) reads, "Lasix 20 mg I BID po." MAR on 2/27/19 reads, "Lasix 20 mg I BID po" continued. | **PART 1**<br><br>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required. | |

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| ☒ | §11-100.1-15 Medications. (m)<br>All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.<br><br>**FINDINGS**<br>Resident #1, order (3/18/19) at emergency room reads, "Increase Lasix 40 mg BID today- see MD tomorrow." No evidence in MAR that this one time order made available. | **PART 1**<br><br>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required. | |

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| ☒ | §11-100.1-17 Records and reports. (a)(1)<br>The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:<br><br>Documentation of primary care giver's assessment of resident upon admission;<br><br>**FINDINGS**<br>Resident #1, primary care giver (PCG) assessment incomplete upon admission:<br><br>1. Physician certified (1/30/19) resident as non self-preserving; however, PCG indicates (2/2/19) certified as self-preserving.<br>2. Physician orders (2/2/19) compression stockings daily and fluid restriction 2 L/day; however, no evidence of orders available in assessment.<br>3. No signature by the resident upon admission. | **PART 1**<br><br>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required. | |

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| ☒ | §11-100.1-88 Case management qualifications and services. (c)(1)<br>Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:<br><br>Conduct a comprehensive assessment of the expanded ARCH resident prior to placement in an expanded ARCH, which shall include, but not be limited to, physical, mental, psychological, social and spiritual aspects;<br><br>**FINDINGS**<br>Resident #1, no documentation in the comprehensive assessment on which to address the following:<br><br>1. Dysphagia and<br>2. Orders (2/2/19) regarding daily fluid restriction, special diet and compression hose stockings | **PART 1**<br><br>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required. | |

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| ☒ | §11-100.1-88 Case management qualifications and services. (c)(4)<br>Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:<br><br>Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions;<br><br>**FINDINGS**<br>Resident #1, the care plan did not reflect a change in diet ordered on 4/16/19. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** | |

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____